Royal Papworth Hospital
NHS Foundation Trust

Agenda item 5

Report to:	**Board of Directors**	**Date: 05 Sept 2024**
Report from:	**Chair of the Quality & Risk Committee**	
Principal Objective/ Strategy and Title	**GOVERNANCE:** **To update the Board on discussions at the Quality & Risk Committee**	
Board Assurance Framework Entries	675, 742, 3040	
Regulatory Requirement	Well Led/Code of Governance:	
Equality Considerations	To have clear and effective processes for assurance of Committee risks	
Key Risks	None believed to apply	
For:	Insufficient information or understanding to provide assurance to the Board	

1.Significant issues of interest to the Board.

1i. CPE outbreak. We have followed progress against this outbreak and been hugely reassured by how quickly it's been contained - and recognise the efforts of all concerned. There was no significant patient harm and although there was some reshuffling of procedures, there was no overall reduction. Single rooms were probably a significant factor. **Assurance**: good.

1ii. Infection prevention and Control Annual Report. The Committee ratified the report and recommends it to the full board for approval. It details much excellent work, which the committee reviews regularly. The one continuing puzzle about infection control is that RPH has responded superbly to urgent problems – during Covid for example, or the CPE outbreak (not included in this report as it covers 2023-24), and at these times SSIs also seem to fall significantly (includes latest data, subject to confirmation). This suggests that simple rigour and determination can have an appreciable effect on SSIs. Our exhaustive search for other contributory factors continues but, as we note in the next item, human factors remain the biggest concern.

1iii. SSI summit. The summit took place on August 8th, attended by about 140 people. It was a chance to take stock, bust some myths, disseminate current understanding (particularly about ventilation and the costs and benefits of vein harvesting), listen to new ideas, and get a consensus about how to procced. All of these we judge to have been achieved. For example, there was agreement to reduce the numbers in theatre from 14 to 12; and that diabetes management needs to be improved with training to maintain more measured glycaemic control. However, we cannot know if these will deliver results. That will depend in part on commitment from the teams – for example to make the objective to reduce footfall work (video feeds from theatre are technically possible, but not everyone likes the sound of them). It will also depend on resource: retraining nurses for diabetes management involves overcoming

understandable anxieties and old habits and will not happen instantly. These are good objectives: the next piece of work will be to set out how we will track progress.

Our **assurance** in the governance of SSIs remains **good**. We commended the work at the summit, for example. Assurance about outcomes has to remain **limited or moderate**. We note that SSIs in the latest data are much reduced, though these are often revised as more cases come in, and may be related to efforts to contain the CPE outbreak.

1iv. Review of harms to waiting patients. This report has been a while coming and was welcomed by the committee. There is good practice in some areas – e.g. oncology – others are more patchy. Divisions will discuss this. We discussed whether harm reviews pick up the things that matter and were advised that in the case of cancer outcomes, the answer is probably yes. Overall, we feel assured that known patient deterioration on RTT pathways is urgently reviewed, and treatment prioritised, but acknowledge there are still a lot of unknowns about waiting patient experience and so judge that **assurance is moderate**.

1v Safeguarding annual report. We ratified this report and recommend it to the full board for approval. There are very few safeguarding cases at RPH, but the report shows the scale of the effort to maintain the machinery of compliance. This is on the whole well done, but we will explore ways to share the work with the teams at CUH, to try to ease the burden.

Our patient story in July was about making reasonable adjustments for a patient with autism - which probably made all the difference for a successful outcome. **Assurance** on safeguarding: **good.**

1ii. Clinical audit. We discussed the process of selection of clinical audits and approved the annual programme.

1iii. Coroner. We discussed the consequences of a rising number of cases and growing coroner backlog. Coroner cases are a significant burden and anxiety for staff and patients' families, they sometimes last two or three days, involve several staff, and concern events many years ago. One recent case related to a death in 2018. We do what we can to support families during the process, but on the overall demand we can push back only to a limited extent.

1iv. Self-medication. The PPI committee has expressed anxiety about reports that patients have been unable to self-medicate on wards, so Q&R asked for clearer understanding of the scope and reasons for any restriction. It applied to one ward, did not include insulin, for example, and was in response to a number of safety incidents. So safety was the overall motivation. These incidents had been targeted by a quality improvement project led by two of the nursing staff who described the project to the committee. This included evidence gathering, patient consultation, and communication with staff, new recommendations which will be evaluated, and seemed to us in many ways to have been an exemplary QI project, though it has taken longer than hoped, and we acknowledge the anxiety and inconvenience for some patients in that time. One outcome is that whether self-medication is appropriate will be individually evaluated: some patients prefer not to self-medicate, some need supported self-medication, others staff-administered medication. There will be a new policy, a pilot is underway, and this will be audited. We congratulated the team on their work.
Assurance: good.

1v. TAVI. The Performance Committee has discussed the difficulties of meeting rising demand for TAVI. We have focused on the safety implications at Q&R meetings in June and July, as patient time while waiting can be critical. This included a discussion of transfers in general and the balance of responsibility with the ICB. Several patient deaths have been grouped for a PSII investigation. Pending any increased capacity, an immediate safety concern is to assure that triage is as effective as possible. We discussed some of the triage mitigations. We also noted that the number of points of referral has grown with a risk of patients being lost and that there work is ongoing to look at a streamlined point of entry.

Assurance on outcomes is clearly **limited.** Assurance on governance is **moderate** as this is an emerging risk, but we we do have awareness and understanding of the problem and mitigations on triage are being put in place. We have asked for regular updates.

1vi. PIPR. We took a moment in the July meeting to acknowledge the long and determined efforts to improve VTE assessments which have inched up over many years. This has been a longstanding concern for the committee and is now at about target for the first time. The team takes deserved satisfaction from overcoming some scepticism that this could be done and hopes that we can now embed a culture of continued compliance. **Assurance: good.**

Also of note, we discussed the focus of the safe staffing metric on nursing staff, and whether this needed to be widened to include pharmacy, or any other areas where staffing becomes an issue, as it has been recently in imaging, for example. This was subsequently agreed.

1vii PSIRF. In July, we discussed a briefing from BDO about best practice. We were reassured to see that RPH, whilst not always using exactly the same methods, is very much in line in spirit.

In August, we discussed whether as a committee we're able to keep track of the various incidents, investigations and outcomes as they flow through the PSIRF process. It's acknowledged that because we now have freedom to pick up incidents whether or not they result in harm, there may be more lines of inquiry with a more diverse set of responses. This is a strength of the system, but we look forward to periodic reviews that will summarise the work overall and its effectiveness to give us clarity. Overall, we feel it's working well. We were particularly impressed with the first substantial investigation to report in August - of amputations following surgery. These are rare, and we had no cause for concern. Even so, PSIRF gives us a framework for choosing to search for any common issues and spot potential quality improvements. **Assurance: good**.

1viii Harm Free Care Quality Improvement Panel. This was Q&Rs first and only report from the new panel, set up as a Quality Account priority, which has now met several times. In future it will report to QRMG and only by exception to Q&R, but the board may be interested to note that it is up and running and looks promising. The aim is to triangulate information about falls, pressure ulcers and venous thrombosis embolism and dig for more detail.

2. Policies etc, approved or ratified: DN708 Digital Acceptable Use Policy. DN297 Management of Medical Devices and Equipment Policy. ToR 036 Emergency Preparedness Committee.

3. Matters referred to other committees or individual Executives.

None.